SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 1 9 1961

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 12

-61-002173
STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe — Length of stay in 1b: 10 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe Hospital — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Carroll
c. CITY OR TOWN Hale — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ARTIE Middle Mx M. Last MEEKS
4. DATE OF DEATH: Month Jan. Day 14th, Year 1961
5. SEX: Female
6. COLOR OR RACE: white
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 5/1/1870
9. AGE (last birthday): 90
IF UNDER 1 YEAR: Months 8 Days 13 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (City and state or country): Hale, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Jacob C. Rice,
13b. MOTHER'S MAIDEN NAME: Hannah Kimmel
14. NAME OF HUSBAND OR WIFE: Homer P. Meeks,
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs O. C. Sweeney, Hale, Missouri.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia Terminal — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Occlusion — 1 week
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 10-58 to Jan 14-61 and last saw her alive on Jan 14-61
Death occurred at 6:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph A. Conrad M.D (Degree or title) — 22b. ADDRESS Chillicothe Mo — 22c. DATE SIGNED Jan 16-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE Jan. 17, 1961 — 23c. NAME OF CEMETERY OR CREMATORY Hale Cemetery — 23d. LOCATION (City, town, or county) (State) Hale, Missouri.
24. FUNERAL DIRECTOR Clifford W. Austin — ADDRESS Tina, Missouri
25. DATE RECD. BY LOCAL REG. Jan 16, 1961
26. REGISTRAR'S SIGNATURE Amalie Taylor

(Licensed Embalmer's Statement on Reverse Side)

US JAN 19 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Clifford W. Austin
Clifford W. Austin

Licensed Embalmer No. #3233

P. O. Address Tina, Missouri.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.